ICF/IID ACD Delivery and Completion of Purchase Confirmation

ICF/IID Service Provider	DADS Contract No.
Resident Name	Date of Purchase/Delivery
Resident Address (Street, City, State, ZIP Code)	
Description of the Augmentative Communication Device (ACD) System	Invoice Cost of Item $

Section I — Resident Satisfaction

☐ I am satisfied with the ACD system delivered.

☐ I am not satisfied with the ACD system delivered. Explain why and document recommendation(s) for resolution:

☐ I have received orientation/training in its use and do not require additional training.

☐ I am satisfied with the ACD system, but I need more training in its use. Document additional orientation/training needed and hours required:

Signature–Resident/Legally Authorized Representative (LAR)	Date
Signature–ICF/IID Provider Representative	Date

Section II — ICF/IID Provider Determination

☐ The item meets the documented need(s) of the resident based on the recommendations for the ACD system documented by the Speech Therapist on Form 8728, ICF/IID Augmentative Communication Device (ACD) System Authorization.

☐ The item **does not** meet the documented need(s) of the resident. Explain why and document recommendation(s) for resolution:

Signature– Provider Representative	Date

Provider Representative Printed Name	Provider Representative Title